FAMILY INTERVENTIONS FOR FAMILY PHYSICIANS

I. WHAT IS HEALTHY, WHAT IS SICK? (ASSESSMENT): myths about families (Handout 1)

A. What is a dysfunctional family?: hard to say, except that we all know we come from one

B. Assessment dimensions (Handout 2)
   1. Firm rules----adaptability
   2. Autonomy & individuation----support & family closeness

C. Other assessment dimensions
   1. Family structure and roles (authority, decision-making)
      a. Subsystems (spousal, parent/child)
      b. Coalitions
      c. Triangulated situations
   2. Value orientation and goals
      a. Cultural context
      b. Socioeconomic status
   3. Communication styles
      a. Open/closed
      b. Intellectual/affective
   4. Stage of family life cycle

D. Healthy families
   1. Capacity to communicate thoughts and feelings
   2. Cardinal role of parental coalition in establishing level of functioning of total family
   3. Capacity to deal with stress/master life stages, including separation and loss
   4. Ability to maximally utilize personal and family resoures
   5. Mutual respect for other family members
   6. Ability to deal with conflict

E. Troubled families
   1. Dominated: one powerful authoritarian parent, often emotionally or physically abusive; little or no closeness
   2. Conflicted: parents unable to share power; struggles for control
   3. Chaotic: disorganized, isolated, may seem bizarre
   4. Closed: may be either chaotic or rigid, little interaction with outside world
   5. Perfect: appearance of close, open relationship, but in reality great distance, anger among family members
   6. Centripetal (enmeshed)
      a. Absence of parental coalitions; leadership absent
      b. Difficult to tell who is parent, who is child
      c. Individuality discouraged; emphasis on family closeness
      d. Lack of boundaries between sybsystems
      e. Inability to negotiate differences
   7. Centrifugal (disengaged)
      a. Open discord, manipulation
      b. Confusion about roles; leadership shifting
      c. Blaming, intimidation, quarreling
      d. Lack of warmth, tenderness
      e. Members go their own separate ways

F. Red flags in assessment
1. Inability to deal effectively with developmental sequences and family crises
2. Extremely problematic communication patterns
a. Double-binds: two simultaneous but contradictory messages)
b. Mystification ("fog"): obscuring, befuddling;way of avoiding conflict and contradictory viewpoints
3. Scapegoating: reliance of family system on maintenance of pathology in identified patient
4. Detouring: parents deflect conlict onto psychosomatic symptoms of child
5. Pervasive physical symptomatology in family members
6. Alcoholism, drug abuse, juvenile delinquency, violence

G. Guidelines for treatment/referral
1. Refer
a. Chronic conditions, diagnoses
b. Chemical dependency
c. Chronic dysfunctional family patterns
d. Serious acute family symptoms (child abuse, incest, spousal abuse)
2. Treat
a. Family transition/life stage problems
b. Problems of recent origin
c. Illness-related problems

II. LEVELS OF INTERVENTION (Handout 3)
A. Minimal: only contact with individual patients
B. Work with families through individual
C. Discuss medical information with more than one family member present (modified family conference)
D. Discusses feelings and support needs with family members; examines psychosocial impact of illness
E. Planned family meetings and systematic assessment
F. Family therapy

III. META-APPROACHES IN FAMILY INTERVENTION
A. Maintenance: keep things as they are overall; work within framework;emphasize positive
B. Stress: accentuate tension (paradoxical intention, confrontation)
C. Repair: offer family chance to modify itself (behavioral strategies, restructuring)

IV. FAMILY THERAPY VS. WORKING WITH FAMILIES (Handout 4)
A. Working with families
1. Emphasizes maintenance
2. Emphasizes strengths, resources
3. Techniques emphasize reinforcement of positive patterns, optimism regarding change, and reframing
B. Family therapy
1. Emphasis on dysfunction, pathology
2. Active change skills (altering reinforcement contingencies,paradoxical intention, confrontation, restructuring)

V. SEQUENCE FOR FAMILY INTERVENTION (Handout 5)

A. Complaint raised and family assembled
B. Interactions of family members observed
C. Problematic patterns of interaction, if any, identified
D. Goals mutually established
E. Tasks assigned to family members, who are motivated to fulfill them
F. Task completion and progress monitored at follow-up

VI. BASIC TECHNIQUES
A. Education
B. Reinforcement/encouragement (Cheerleading)
C. Optimism/hope (Crisis as Opportunity; "each defect a treasure"
D. Reframing (Look on the Bright Side)
E. Theory of natural consequences (Step out of the Way; Life is a Teacher)
F. Solution-oriented approach (That's the question, now what's the answer): view family members as active partners
1. Identification of the problem
2. How to find solutions
a. The answer lies within: What have you done in the past, what are you doing now that sometimes works, what do you think might work, what existing resources do you have that you can bring to bear on the problem?
b. Do something different: supports family-initiated change
c. A lot of people in your situation would have...: make new suggestion to break out of old patterns

VII. COMMON PROBLEMS/QUICK-FIX SOLUTIONS
A. Untangling enmeshment
1. Reinforce boundaries, autonomy, structure
2. Help members develop own identities, recognize own needs
B. Counteracting disengagement
1. Positive reinforcement
2. Expression of feelings
3. Physical affection
4. Family activities
C. Behavior problems
1. Family contracts to alter contingencies to reinforce desired behavior
2. Set limited, achievable goals (successive approximation)
D. Communication problems
1. Establish basic rules of communication
a. No rudeness, name-calling, bad language
b. I statements (When you, I feel)
c. Paraphrasing and clarifying
2. Establish set times for communication

VIII. RESTRUCTURING THE FAMILY (Handout 6)
A. Cross-generational enmeshment

B. Detouring
C. Undermining grandmother
D. Chaotic family

WORKING WITH FAMILIES	FAMILY THERAPY
THEORETICAL 1) ~~EPISTEMOLOGY~~	SYSTEM'S THINKING INTERACTIONAL THINKING
2) OBJECTIVES	
- MAINTENANCE - MAXIMIZE HEALTH AND DISEASE MANAGEMENT USING CURRENT FAMILY CHARACTERISTICS	- CHANGE - INTERVENE IN A FAMILY SYSTEM WHICH IS MALADAPTIVE DURING PERIODS OF TRANSITION AND LACKS THE ABILITY TO GENERATE ALTERNATIVES
- SUPPORT THE FAMILY SYSTEM'S ADJUSTMENT THROUGH STRUCTURAL, DEVELOPMENTAL OR IDIOSYNCRATIC CRISES	

{ emphasize strengths, positive coping

- identify resources

WORKING WITH FAMILIES	FAMILY THERAPY

3) **SKILLS**

- ESTABLISH A WORKING RELATIONSHIP (JOIN)

- RECOGNIZE THE STRUCTURE, FUNCTIONING, STAGE OF DEVELOPMENT OF THE FAMILY AND ITS USE OF EXTERNAL RESOURCES; Build on past successes
- ANTICIPATE CHANGES AND SUPPORT THE FAMILY DURING TRANSITIONAL STAGES

- RECOGNIZE THE DYSFUNCTIONAL PATTERNS

- Refraining

- RECOGNIZE THE DYSFUNCTIONAL FAMILY STRUCTURE OR INTERACTION

- ATTEMPT CHANGE BY:
  - CLARIFYING BOUNDARIES AND COMMUNICATION PATTERNS
  - REFRAMING THE PROBLEM
  - ALLOWING THE FAMILY TO FIND ALTERNATIVE WAYS OF DEALING WITH EACH OTHER IN THE PRESENCE OF THE THERAPIST

MORE ADVANCED SKILLS

- Alter reinforcement contingencies, so family members reinforce desirable behaviors in each other
  - * shaping
  - * successive approximation
- Paradoxical intention
- Confrontation

Intervention

TABLE 1 - A FAMILY ~~THERAPY~~ SEQUENCE

1. Complaint raised
2. Family assembled in office
3. Interactions of family members observed
4. Problematic pattern of interaction identified
5. Tasks to change the observed pattern assigned
6. Family members motivated to carry out tasks
7. Task completion and progress monitored at follow-up appointment
8. Therapist may recycle to step 3 if necessary

Table 2

Levels of Family Involvement

Level 1. Minimal emphasis on family
Physician deals with family only for medical and legal reasons or to build rapport

Level 1A. Discusses family issues with individual patient
Physician deals with the patient's medical concerns and feelings and explores family context factors without family present

Note: higher levels require the presence of others with the patient

Level 2. Discuss medical information/advice with family
Physician obtains and gives medical information and advice to persons accompanying the patient

Level 3. Discusses feelings and support with family members
Physician discusses feelings of the family toward the patient's condition and treatment and gives added support to the family

Level 4. Planned family meetings and systematic assessment
Physician meets with family for specific reasons and/or systematically assess the family

Level 5. Family therapy
Physician conducts counseling intended for long-term change, improve communications, etc (i.e., professional therapy)

Adapted from Doherty WJ, Baird MA. *Development Levels in Family-centered Medical Care.* Fam Med 1986; 18:153-6.

Shapiro

BEHAVIORAL SCIENCE SEMINAR
MARCH 1995
FAMILY ASSESSMENT AND TREATMENT

LEARNING OBJECTIVES

The learner should be able to:

1. Know how to conduct a brief clinical assessment of family systems, including adaptability/cohesion, strengths/resources and weaknesses, communication style and preferences, and decision-making.

2. Define common terms used in family therapy such as subsystems, coalitions, triangulation, and detouring.

3. Differentiate between healthy and dysfunctional families, listing particular indices of families in trouble.

4. Identify patient problems from a family and systems perspective, as well as from an individual point of view.

5. Describe brief techniques of "working with" families, including the wellness model, behavioral approaches, brief family therapy, and simple structural family therapy strategies.

6. Describe different levels of physician involvement with the family, including minimal emphasis, ability to give ongoing medical information and advice to family members, skills to enhance family support, systematic assessment and planned intervention with families, and formal family therapy.

MENU OF LEARNING EXERCISES

1. Prepare a brief annotated bibliography of family therapy approaches used in family practice settings (10 references). **(Option for two residents.)**

2. Make a videotape of an interview with a family, focusing on a particular problem. **(Required presentation one week.)**

3. Interview a family therapist, or a family physician who does a lot of work with families. **(Option for two residents.)**

4. Develop a role-play situation modeling a brief family therapy intervention.

5. Describe the steps of identifying family dimensions to a patient problem (i.e., noncompliance, persistent psychological distress etc.), assessing family, developing an intervention or making a referral, using as an example a patient from your own practice.

6. Use examples from your own personal experience (family, friends etc.) to illustrate how a family-oriented approach can be successful in treatment of psychosocial and/or medical concerns.

FAMILY ASSESSMENT

I. Dimensions of Assessment
   A. Nature of presenting problem
      1. severity of symptomatology
      2. role of symptom in family
   B. Family structure
      1. overt power (influence and dominance vs. leadership in family)
      2. parental coalitions:child coalitions
      3. closeness (boundaries)
      4. family rules and means of enforcing
      5. role network with extended family community
   C. Family goals and value orientation
   D. Mythology
      1. shared distortions, stereotypes
      2. degree of congruence between family and observer impressions of family
   E. Goal-directed negotiation
      1. effectiveness of family negotiations
      2. problem-solving skills
   F. Previous response to crises
   G. Communication patterns
      1. clarity, directness
      2. congruence between verbal and nonverbal
      3. who talks to whom and how
   H. Family affect - dealing with affect
      1. expressiveness
      2. mood and tone, warm affectionate vs. cynical, pessimistic
      3. conflict - degree of <u>unresolved</u> conflict
      4. empathy - sensitivity to feelings of others
   I. Degree of autonomy of family members - individuation
      1. ability to communicate self-concept (sharing feelings and thoughts)
      2. responsibility (for own thoughts, feelings, actions)
      3. invasiveness - speaking for one another, mind-reading
      4. permeability - receptivity to each other's acknowledgment of what others' thinking, feeling
   J. Stage of family life cycle
      1. accomplishment of appropriate developmental tasks
   K. Capacity for change

II. Ten Key Questions in Family Assessment
   A. What is outward appearance of family?
      1. how far apart do family members sit from each other?
      2. who sits next to whom?
      3. who is closest to therapist?
      4. physical appearance (resemblances, neatness, cleanliness)

B. What is cognitive functioning in the family?
   1. capacity for precise communication
   2. degree of effective problem-solving
   3. contradictory messages
   4. who gives and who receives various communications
C. What is repetitive, non-productive sequences do you notice?
D. What is the basic feeling state of the family?
   1. who carries it?
E. What is the quality of relationship between family?
   1. how do people relate to each other?
   2. how well are they able to communicate, to share feelings?
F. What subsystems are operative in the family?
   1. coalitions
   2. triangulated situations
G. Who carries the power in the family?
H. How are family members differentiated from each other? (autonomy)
I. What part of the life cycle is the family experiencing?
   1. are its problem-solving methods appropriate?
J. What are evaluator's own reactions to family?
   1. reminds of own family
   2. affect (warmth, dislike, anger etc.)

III. More Right Questions
A. Families of Origin
   1. who is the family of the family?
   2. what sort of families did the parent generation come from?
   3. use of genograms to identify transgenerational patterns of dysfunction
B. Value Orientation
   1. what are particular values held by this family?
   2. what beliefs are important to them?
   3. are religious beliefs important to the family?
   4. are there value conflicts between family members, particularly across generation?
C. Social Milieu
   1. how much contact with relatives? helpful/difficult?
   2. do family members have friends in the neighborhood?
   3. to what groups, organizations do family members belong?
   4. employment/income status? level of education of members? school attendance/problems?
   5. what is the physical environment in which family lives?
D. Psychosocial Interior
   1. who are major decision-makers in family?
   2. who can each person talk to most easily?
   3. how does each member get attention?
   4. what activities does the family share? what about only some?
   5. what are roles each family member assumes?

E. Family life cycle
   1. how many are there in the family?
   2. who lives at home?
   3. what family concerns/problems do they presently have?
   4. what major problems has this family experienced in past; how have they resolved them?

F. Family Life
   1. what is daily life like for this family and its members?
   2. what are their routines?

IV. Distinguishing Functional and Dysfunctional Family Systems

A. Health families
   1. capacity to communicate thoughts and feelings (key)
   2. cardinal role of parental coalition in establishing level of functioning of total family (key)
   3. ability to successfully love, work, and play
   4. freedom from symptoms
   5. capacity to deal with stress
   6. ability to master life stages
   7. ability to maximize personal resources
   8. open, caring, empathic, trusting communication between members
   9. mutual respect for other family members:shared power
   10. freedom to agree or disagree without punishment
   11. closeness, but also autonomy:good boundaries
   12. ability to deal realistically with separation and loss

B. Troubled families (severely dysfunctional)
   1. great difficulty dealing with adolescent separation
      a. centripetal - cling together; family binds children;
      b. centrifugal - distancing from family, reliance on peers; children expelled often before they are ready;
   2. dominated: one powerful parent; little or no closeness
   3. conflicted: parents unable to share power; struggles for control
   4. chaotic: disorganized, isolated, may seem bizarre
   5. completely closed system - chaotic, rigid, little interaction with outside world
   6. centripetal
      a. absence of parental coalitions; leadership absent
      b. difficult to tell who is parent and who child
      c. individuality discouraged: emphasis on family closeness
      d. children fail to establish separate identities
      e. lack of boundaries between subsystems
      f. communication poor and confusing
      g. absence of warmth
      h. inability to negotiate differences

7. Centrifugal
   a. open discord, manipulation
   b. confusion about roles: leadership shifts moment to moment
   c. blaming, intimidation, quarreling
   d. lack of warmth or tenderness
   e. inconsistent rules

VII. Red Flags in Assessment

A. Inability to deal effectively with developmental sequences and family crises
   1. regression
   2. disorganization
   3. major dysfunction

B. ~~Pathological~~ communication
   1. double-bind: issuing two simultaneous but contradictory messages
   2. mystification:
      a. befuddling, obscuring, masking
      b. way of dealing with conflict and contradictory viewpoints
   3. quality of communication:
      a. symmetrical
         1. each participant attempts to mirror other's behavior
         2. may either minimize conflict or be competitive
      b. complementary
         1. one partner's behavior complements the other
         2. based on inequality

C. Enmeshment and disengagement
   1. families functioning on either extreme of continuum at risk
   2. juvenile delinquency as index of either enmeshment or disengagement
   3. psychosomatic symptoms in child as index of enmeshment

D. Scapegoating
   1. reliance of family system on maintenance of pathology in identified patient
   2. all members, including scapegoat, participate in the process

E. Persistent family myths
   1. shared fantasy, denial, distortion contradicting reality
   2. used to maintain dysfunctional interaction patterns

F. ~~Pseudomutuality~~
   1. attempt to maintain appearance of close, open relationship
   2. in reality, great distance between family members

G. Pervasive ~~physical~~ symptomatology in family members

H. Alcoholism, drug abuse

FAMILY AND ILLNESS

I. Overview
   A. Disease and illness distinction
      1. disease - physical dysfunction, symptomatology
      2. illness - psychosocial response to disease
   B. Importance of family emphasis
      1. contrast to focus exclusively on doctor-patient dyad
      2. need to emphasize family context
   C. Family as health/illness defining unit
      1. children learn illness perceptions from parents
      2. different cultures, socioeconomic groups have differing interpretations of illness
      3. families experience illness as a unit
      4. families display identifiable patterns of disease, propensities toward certain illnesses
   D. Relation of a family to illness
      1. may influence course and outcome of illness
      2. may constitute conditions sufficient to precipitate illness
      3. may act as a predisposing influence - may increase susceptibility to illness

II. Theoretical models: linear vs. systems
   A. Linear - most commonly applied in patient care
      1. individual is identified patient and primary focus
      2. family important for how it affects individual
      3. responses and behavior of individual caused by authors
      4. action and reaction, stimulus and response
   B. Systems model
      1. family seen as organic unit, dynamic system in which every part seen as simultaneously organizing and being organized by other parts
      2. functions in interactive, reciprocal patterns; every part both caused and causative
      3. system tends to homeostasis, balance; can be thrown into disequilibrium by crisis
   C. Linear model yields change in individual, not in system
   D. Ignoring family environment risks inability to generalize newly acquired adaptive behaviors

III. Dimensions of Assessing Family Response to Illness
   A. How family has dealt with previous crises
   B. Meaning the illness has to the family and to ill member
   C. Family life-style/structure
      1. when family is nurturing, well-structured, and has open communication, response to illness is more adaptive
   D. Coping resources
      1. emotional strength of family members
      2. support from extended family
      3. availability of necessary resources
      4. self-help groups
      5. religious beliefs
   E. Who is ill
      1. status and role of ill family member
   F. Stage of the family life cycle

G. Stage of disease
1. preventive efforts
2. diagnostic crisis
3. treatment
4. rehabilitation and recovery or death
5. at each stage, various clusters of roles to be performed
a. some family functions continue without disruption
b. some redistributed temporarily
c. some permanently reassigned
d. some new functions created

III

IV. Effects of Illness on the Family

A. Dysfunctional effects
1. disappointment, shame, guilt, inadequacy
2. resentment and anger, yielding punishment, ignoring of ill member
3. anxiety, yielding overprotectiveness, overindulgence
4. depression and unresolved grief
5. marital dysfunction
6. overconcentration of attention on sick member; child-rearing practices distorted
7. distortion of family life
8. secondary gain
9. chronic stress - main goal survival; little hope of accomplishment
10. lethal dyads: a see-saw of symptoms between family members
11. web of silence: lack of communication, patient isolation
12. social isolation of the family
13. family postpones or avoids seeking help
14. patient develops low self-esteem; withdrawal; dependence; anger
15. family breakdown and distintegration
16. infringement on leisure time, work time

B. Positive effects
1. family feels they have become closer as a unit
2. family members feel they have grown on a variety of personal, interpersonal dimensions as a result of the experience
3. development of a more positive and humorous worldview
4. development of unusually deep and meaningful friendships
5. encouragement of independence and normalcy in ill member ✓ pg 2

C. Models describing effects of illness on family
1. Pearse (1977): Shock - Denial - Guilt - Anger - Sense of normalcy
2. Dortar et al (1975): Shock - Denial - Sadness/anger/Anxiety - Adaptation - Reorganization
3. Bray (1977): Anxiety - Acceptance - Assimilation
4. Epperson (1977): Anxiety - Denial - Anger/Remorse/Grief - Reconciliation
5. Giacquinta (1977): Living with Cancer: Impact - Functional - Disruption - Search for Meaning - Informing Others - Engaging - Emotions - Restructuring - Reorganization - Framing Memories - Bereavement - Separation - Morning - Reestablishment
6. Characteristics of models
a. stages not necessarily sequential
b. stages may be ommitted or reverted to
c. different family members may be in different stages at different times

V. III Coping Tasks and Strategies

A. Goals of coping
1. challenge to family adaptation
2. important for family to maintain sense of membership for ill person
3. important task for family reorganization, reassignment of roles
4. reestablish emotional baseline - mastery of resentful, self-accusatory feelings ✓

B. Coping strategies
   1. denying, minimizing, avoiding
      a. of facts
      b. of meaning of facts
      c. of one's emotional state
   2. seeking relevant information
   3. requesting reassurance and emotional support
   4. learning specific illness-related procedures
   5. setting concrete, limited goals
   6. rehearsing alternative outcomes
   7. finding general pattern or meaning
   8. isolation of affect - isolate and deny anxious emotions, especially during medical crisis
   9. rationalization - focus on enriching aspects of experience
   10. control through thinking - mastery of information
   11. maintaining a sense of control
      a. over life in general
      b. over outcomes of this illness
      c. through personal efficacy (participating in recovery process)
      d. through belief in powerful others
   12. acceptance
      a. positive - continue to live as fully as possible; "insightful"
      b. resignation and giving up
   13. maintaining hope or optimism
   14. use of mental imagery
   15. prayer
   16. humor, laughing
   17. adopting or avoiding the sick role
   18. making positive life changes
   19. stress reduction behaviors
      a. meditation, relaxation
      b. smoking, watching TV, drinking
   20. escape, distraction
   21. expression of feelings

C. Maladaptive coping responses
   1. severe and unchanging denial of reality of illness
   2. isolation of ill member while rest of family attempts to survive
   3. hypochondraisis in other family members
   4. continued projection of angry feelings onto other family members
   5. extreme regression on part of children
   6. extreme rigidity
   7. significant withdrawal from accustomed social interactions

VI Guidelines for Intervention
A. Importance of providing explanatory models to family members
B. Encouraging open communication
C. Using information constructively
D. Sharing parental anxiety
E. Identifying and emphasizing parental strengths
F. Teaching specific treatment techniques
G. Use behavioral rehearsal to prepare family for different possible outcomes

THERAPEUTIC CORE QUALITIES

I. RESPECT

* Ability to accept other as unique person
* Nonjudgmental
* Being attentive, focused on other

II. GENUINENESS

* Ability to be oneself in relationship
* Expressing appropriate feelings

III. EMPATHY

* Ability to sense other's experience and feelings accurately and communicate them back to other
* Show other she is understood
* Help other clarify what he is feeling

Please remember

LISTENING SKILLS

1. Have a compassionate, caring concern for the ~~speaker~~ patient/family

2. Cultivate a respectful, nonjudgmental attitude toward the ~~speaker~~ patient/family

3. Take your time - periods of silence can be useful and healing.

4. Use attentive nonverbal behaviors, such as eye contact and posture, to keep exclusive focus on the ~~speaker~~ patient/family

5. Use touch in an appropriate, reassuring manner ~~(especially with infant)~~

6. Pay attention to your voice tone; the speed of your words; as well as these aspects of the ~~speaker's~~ communications.

~~7. Allow the speaker to initiate the conversation~~ patient/familys

8. Encourage description and elaboration through WH questions

9. Help the ~~speaker~~ patient/family to clarify and express feelings through the use of minimal encouragers and open-ended questions

10. Note discrepancies between verbal and nonverbal communication

11. Attend to, and be willing to make observations about, nonverbal behaviors of the ~~speaker~~ patient/family

12. Express your own desire to understand the other, as well as, when appropriate, your own feelings of sadness, confusion

13. Clarify - through paraphrasing and restatement - to make sure you are hearing what the ~~person~~ patient/family is saying.

14. Be aware of, and willing to comment on, the emotional as well as the content message of the speaker;

15. Listen for the questions behind the questions

~~16.~~ Validate by acknowledging that the feelings, thoughts, confusions of the speaker are genuine; it is OK to express emotion

17. Provide information and explore alternatives

18. Encourage ~~person~~ patient/family to set goals and plan activities toward those goals

19. Be willing to set limits with ~~the speaker~~ patient/family based on your on abilities, skills, and resources

20. Summarize and review significant points of the communication

COMMON MISTAKES

1. Change the subject (blocks communication)

2. Give meaningless reassurance (reduces credibility)

3. Give stereotyped replies or ~~use clichés~~ glib advice (it makes the ~~person~~ patient/family feel that their feelings or communication are trivial)

~~4. Giving advice (usually, if solutions were that easy, the person could have figured it out on their own)~~

5. Excessive self-disclosure (you are not there to talk about yourself)

6. Show disapproval, judgment (~~person~~ patient/family will withdraw)

7. Ask closed-ended questions (tend to limit other's ~~person's~~ response; encourages you to do most of talking)

8. Speak and act inconsistently (smiling and laughing when you are nervous)

9. Ask questions that begin with the word "why?" (indicates you want the ~~person~~ patient/family to justify their statements)

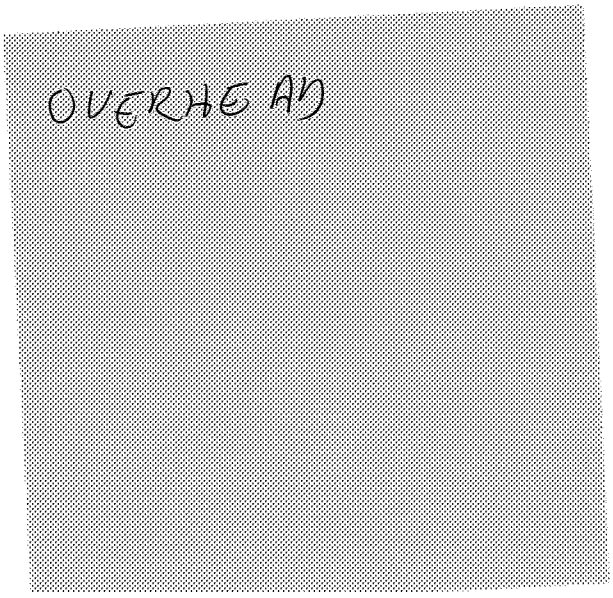
~~10. Talk in broad generalities (your intention is to focus on the unique individual in front of you)~~

~~11. Talk too much (you are there to LISTEN)~~

~~12. Be excessively positive or negative (a cheerleader or a wet blanket)~~

13. Tell someone else how to feel (only the ~~person~~ family knows ~~her~~ their own feelings)

14. Use complicated or technical language (confuses others, tends to create distance between you and them)



FIVE STAGES OF COPING (GRIEF)

Parents or families of children who have a developmental disability progress through five stages. These five stages are in response to the loss of an expected "normal" child.

The rate at which parents pass through these stages depend upon a number of factors (eg., their coping mechanisms, spousal relationships, available support outside the family, culture, etc.).

Parents may and frequently do pass through these stages again when they have to cope with a new problem, crisis, or stress. For example, parents may experience these feelings or stages during the following times:

- diagnoses
- hospitalization
- marital stress
- IEP
- dealing with individuals outside the family
- placement
- puberty

The following pages outline the stages of grief, provide a brief description of some of the characteristics you may observe.

STAGE	CHARACTERISTICS OF PARENTS	POSSIBLE SUPPORT
Denial	-Confusion about what is happening to their child or what is happening to them -Fear about what may happen to their child -Fear about what may be wrong with their child -Mistrusting of what professionals are doing -Parents ask lots of questions -Optimistic/pessimistic fantasies about what happening to child -Fear about future -Denial:Not acknowledging what they see, hear or that what they see or hear applies to them -Denying certain aspects of the problem/handicap (eg., deny diagnosis, severity of MR, etc.) -Deny reasonable implications for future	-Listen to parent -Validate the parents' feelings, It's OK to feel concerned, confused, etc. -Encourage them to talk about their feelings -Support the seeking of answers/information -Support the seeking of information from reliable sources (eg., diagnosis from a qualified physician, informing conference, readings, support groups, etc.). -Encourage sharing between spouses, they need each other's support -If asked, share some of your experience (It is important for parents to know they are not the only ones to have felt this way)
Anger (Guilt and blaming)	-When denial is no longer useful in coping, there is often a need to place blame/guilt or become angry -Anger towards physicians -Anger towards spouse -Anger toward world (Nobody understands) -Anger toward disabled child -Anger toward other professionals, agencies, teachers, relatives, etc. -Parent will direct anger/blame towards themselves (eg., "What did I do during pregnancy?", etc.) -Oversensitivity (responding to every comment relating to their child or developmental disabilities)	-LISTENS (This is very important as we tend to be defensive when someone is angry or become angry ourselves) -<u>Encourage parent to talk about anger</u> -It is OK to be angry, <u>let parents vent their anger</u> (there is often a justifiable reason for it) -Listen and <u>explore how parent intends to resolve anger</u> (discuss the options) -Explore realities of situation (What really happened to induce the anger?)
Bargaining (Hope)	- Having hope is a natural aspect of being human. However, "excessive" or "unreasonable" hope can drain energy, create stress, and set a person up for failure -Parent searches for a "miracle" cure -Parent participates in "alternative therapies" which promise results, but have not documented the process or the validity of the results -Parents shop around for physicians, therapies, programs, services, etc. -Parents devote an enormous amount of time to child, usually to the detriment of spousal and family relations -Parents have "unreasonable" demands from IEP, Regional Center, etc.	-Listen to parent -Explore their feelings and expectations -Be sensitive to whether they are very confident in their expectations or asking for feedback -Provide information about programs/therapies which come from a source <u>other</u> than the program which they are considering -Help them digest and understand this information but DO NOT advise them to try avoid the program(it is their decision) -<u>Explore other priorities</u>, responsibilities in their life

Depression	The characteristics of this stage may be mild or severe, but include: -sadness -loss of interest, energy -isolation from others -crying -"not caring anymore" -feeling of inadequacy or worthlessness -feeling helpless, ineffective	-BE THERE -Encourage parent to share feelings -It's OK to fee sad and cry (and the support parent may shed some tears also) -Reassure parent they are not alone -Share when appropriate (misery does love company sometimes) -Support and encourage the acceptance of the disability -Allow parents the freedom and emotions to come to terms with the situation -Be alert for suicidal tendencies
Acceptance	-Parents accept themselves and their child -Feel comfortable with parent-child relationship -Parent feels comfortable in dealing with other people, professionals regarding their child -Parents deal more in the present regarding their child	-LISTEN (and learn) -Provide support in areas where parents need it -Realize this parent (as do you) may again pass through previous stages in times of stress
Understanding	-Sense of being enriched, strengthened by the child's presence -Desire and ability to help others -Attitude of fulfillment -Feeling of having grown as a person	-None: we can learn a great deal from these parents